STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2253	A. BUILDING _____ B. WING _____	C 07/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTECITO SANTA FE (THE)	500 RODEO ROAD SANTA FE, NM 87505

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a complaint investigation completed on 07/12/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint intake #37012 was substantiated with deficiencies cited.	A 000		9/23/2019
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the	A 032	REPORTING OF INCIDENTS: A. The facility will insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility will also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility will not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and will submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, will be maintained on file at the facility. The investigation will include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation will be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the Incident C. All staff and administrative directors at the facility will go through an in-service and training on reporting requirements of incidents during orientation and annually. Documentation of orientation and subsequent trainings will be kept in the personnel file at the facility.	

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A 032	Continued From page 1 incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next	A 032	(Employee records maintenance) D. Employee personnel records and documentation of orientation and subsequent trainings shall be maintained on-site by the Human Resources Director to ensure ongoing compliance.	

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A 032	Continued From page 2 business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. If the facility is not reporting incidents to the Licensing Authority then there would be no oversite to protect the residents from being abused, neglected, and/or injured. The findings are: Based on record review and interview the facility failed to ensure that incidents of alleged abuse or neglect were reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. If the facility is not reporting alleged incidents to the Licensing Authority then there would be no oversite to protect the residents from being abused and neglected. The findings are: A. Record review of complaint Intake #37012 revealed that on 04/29/19, the Wellness Director/Nurse attempted to remove R #1 from the facility lounge as she was sitting on a bench, by pulling on R #1's arm. The complaintant identified this behavior as abuse. B. Record review of the facility self-report revealed that this incident was not submitted to the Licensing Authority until 05/03/19 (Friday). C. On 07/17/19 at 10:40 am, during an interview with the Administrator, he confirmed that the 04/29/19 incident for R #1 was not reported until 05/03/19.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all	A 033		

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A 033	Continued From page 3 residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment;	A 033	9/23/2019 RESIDENT RIGHTS: The facility understands, and will protect and respect the rights of all residents. A. All staff and administrative directors at the facility will go through an in-service and training related to dementia, Alzheimer's disease, resident rights, reporting requirements of abuse, neglect and exploitation during orientation and annually. Documentation of orientation and subsequent trainings will be kept in the personnel file at the facility. B. The facility will ensure that residents are free from abuse and treated with compassion, respect and dignity, and are not at risk of physical or verbal abuse and emotional harm by facility staff. C. The facility will put in place a formal policy for written grievances and complaints. (Employee records maintenance) D. Employee personnel records and documentation of orientation and subsequent trainings shall be maintained on-site by the Human Resources Director to ensure ongoing compliance.	

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A 033	Continued From page 4 (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any	A 033		

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A 033	Continued From page 5 state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (1) (11) (a) Based on record review, observation, and	A 033		

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A 033	Continued From page 6 interview the facility failed to ensure that 1 (R #1) of 1 (R #1) resident was: 1. Free from physical and verbal abuse by facility staff. 2. Treated with dignity, respect, and compassion. If the facility is not ensuring that residents are free from abuse and treated with respect and dignity, then residents are at risk of physical and emotional harm. The findings are: A. Record review of complaint Intake #37012 revealed that on 04/29/19, the Wellness Director/Nurse attempted to remove R #1 from the facility lounge as she was sitting on a bench, by pulling on R #1's arm. The complaintant identified this behavior as abuse. B. On 07/11/19 at 10:28 am, during interview with Direct Care Staff (DCS #2), who stated that he had witnessed WD/N be verbally abusive to resident and had heard that WD/N had been physically abusive with residents as well. Per DCS #2, WD/N would get frustrated with R #1 and either be verbally abusive or ignore her and that WD/N made it very clear that she did not want R #1 or any residents with dementia, especially if they had behaviors, at the facility. C. On 07/11/19 at 11:35 am, during observation and interview with the Administrator, the facility's security video of the incident was reviewed and revealed that on 04/29/19, WD/N was observed pulling, grabbing, and trying to force R #1 to get up from her seat in the lounge. When R #1 refused to stand up, WD/N left the lounge and came back a few minutes later with a wheelchair. At that point the video provided by the facility ended. After viewing the video, the Administrator	A 033		

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A 033	Continued From page 7 stated that the WD/N's actions were inappropriate. The Administrator stated that the WD/N was reprimanded, given a 7-day suspension without pay, had to take a Dementia-training, and then was allowed to return to work. The Administrator stated that WD/N resigned on 05/21/19. When asked if there had been any previous verbal/written reports of WD/N being verbally/physically abusive to residents, he stated No. D. On 07/11/19 at 2:50 pm, during an interview with the WD/N, she said that on 04/29/19, she got a call from the front desk person and someone at the bar who stated that R #1 was being disruptive and rude at the lounge, telling non-resident that they were "fat" and to move out of the way because she could not see the performers. WD/N stated that she tried to get R #1 out of the lounge by offering her a cookie and some tea from the lobby. She stated that R #1 scooted forward to get off of the bench and that she tried to assist her in getting up. R #1 then told her "no" and pulled back to sit down. The WD/N said that she called R #1's daughter who said she would be down in about a hour. In the meantime the WD/N stated that she went back to get a wheelchair to try and get R #1 out of the lounge because she continued to be disruptive. She said that she brought the wheelchair and R #1 scooted forward to get off the bench, she tried to assist her and then R #1 refused to get in the wheelchair. The WD/N said that she finally gave up trying to get R #1 out of the lounge and decided to just check on her every 10 minutes. E. Record review of the Police Report dated [redacted]19 revealed that [name of Officer] conducted an investigation of the alleged incident of physical Abuse of Resident (R #1) by the	A 033		

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A 033	Continued From page 8 WD/N on 04/29/19. The officer concluded that WD/N's statement did not match what was seen on the video and stated in the interviews with the complainant/witnesses, he concluded that WD/N did commit a crime of abuse against R #1 and forwarded the case to the court. F. On 07/12/19 at 11:00 am, during an interview with DCS #1, she stated that she had personally witnessed verbal abuse to residents and staff by the WD/N and that physical abuse by WD/N was reported to her by residents and other staff. DCS #1 said that the WD/N always stayed distant from R #1 but would refer to her as "crazy" and "looney toons." Per DCS #1, WD/N would say the same [calling names] about other residents with dementia and she would always tell the Marketing Manager to not to admit residents with dementia. G. On 07/12/19 at 11:30 am, during observation of a 2nd video (same video the police officer observed) of the incident on 04/29/19 revealed that when WD/N returned with the wheelchair, she was observed speaking with R #1, then again started grabbing at the resident and aggressively pulls R#1 out of her seat towards the wheelchair. She was unable to get R #1 into the wheelchair and started grabbing at her [R #1] again then stopped and continued to speak with her [R #1]. Then the video stops. H. On 07/12/19 at 11:46 am, during an Interview with DCS #5, she stated that on 04/29/19, it was about 6:00 pm, when R #1 came to the lounge to listen to the music. R#1 sat in her favorite spot, she then got up and went up to ladies that were sitting in front of her and told them to move out of the way. The ladies ignored her and R #1 became aggressive and started telling them that they "were fat". DCS #5 said that she called	A 033		

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A 033	Continued From page 9 another DCS to come take R #1 out of the lounge because she was being disruptive. No one came for her, so the lounge staff called again. That is when the WD/N showed up and tried to "forcibly" get R #1 up. Per DSC #5, WD/N looked "furious (red faced)" and then went for a wheelchair and again tried to get R #1 up from the booth where she was sitting but R #1 refused to get up. DCS #5 stated that she and DCS #4 were concerned with WD/N's behavior and wrote up a report and gave it to the front desk, however she was unsure what happened to the report. DCS #5 said that the Administrator told DCS #4 "Don't tell anyone, we will figure this out". That is when DCS #5 decided to resign, because nobody cared about what happened. DCS #4 also resigned her position after this incident. I. Record review of the WD/N's HR file revealed no documentation of any disciplinary actions except for the 04/29/19 incident involving R #1. J. On 07/12/19 at 12:35 pm, during an interview with the Internal Operations/Human Resources Manager (I/HR), she stated that "yes" there were incidents reported of the WD/N being "vindictive" and verbally abusive to the Residents/DCS. She did not receive complaints about her being physically abusive. The I/HR Manager stated that the incidents seemed to increase in the last year, since the WD/N health problems began to increase. The I/HR Manager stated there were verbal and written complaints in her Human Resources (HR) file, she finally had to talk to WD/N about her attitude and behaviors about 1-1.5 years ago. When she was told that there was no documentation of any written/verbal/disciplinary actions in WD/N HR file, except for the 04/29/19 incident with R #1, she stated that maybe the Administrator had	A 033		

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A 033	Continued From page 10 pulled them for the internal investigation and did not know if anything went to corporate. K. On 07/12/19 at 12.55 pm, during an interview with the Administrator, when asked again if he had received any verbal/written grievances from the staff or residents about the WD/N being verbally abusive with residents/staff, he again stated that he had not. L. On 07/11/19 at 1:10 pm, during an interview with the Marketing Director, she said that the WD/N was always inappropriate when discussing residents with dementia, you could always tell she did not have the patience to deal with residents with dementia, especially if they had behaviors. The WD/N's behaviors seemed to increase as her health issues increased. The WD/N would "butt heads" with her when she would want to admit residents with dementia who she thought were appropriate and the WD/N did not. M. On 07/12/19 at 1:00 pm, during an interview with the IO/HR Manager, she stated that the WD/N was the only person she ever got complaints about. She said she did go talk to the WD/N, but does not remember putting anything in writing. The IO/HR Manager reported that 3 people complained about the WD/N behaviors. The IO/HR Manager said that several staff and managers had put in letters of resignation within a month after the 04/29/19 incident, but withdrew them after the WD/N resigned. N. Record review of an email dated 04/20/18 from [name of source] revealed that it was sent to the Administrator informing him of an incident regarding the WD/N's inappropriate comments made to a female resident who was uncomfortable about sitting close to a male	A 033		

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A 033	Continued From page 11 resident because he grabs the women. The WD/N replied to the resident saying "You have nothing to grab." This resident had had a double mastectomy. O. Record review of an email dated 09/20/18 from [name of source] revealed that it was sent to the Administrator informing him of complaints regarding the WD/N's aggressive and verbal abuse of the residents. P. On 07/12/19 at 1:00 pm, during an interview with the Administrator, he confirmed that the HR file for the WD/N he provided to surveyors, had no documentation of any previous verbal or written grievances from staff or residents prior to the 04/29/19 incident. The Administrator confirmed that he did talk to the WD/N about 8 months ago regarding complaints about her attitude/behaviors towards the residents and staff.	A 033		